DEPARTMENT OF SOCIAL SERVICES
ECONOMIC ASSISTANCE

CHILD CARE EXPENSE
BILLING VERIFICATION

_____ was personally **billed** $_____

from _____ 15th through _____ 14th for child care costs for the

following children:

_____	/$_____	_____	_____	/$ _____	_____
Name	Amount	Hours	Name	Amount	Hours
_____	/$_____	_____	_____	/$ _____	_____
Name	Amount	Hours	Name	Amount	Hours
_____	/$_____	_____	_____	/$_____	_____
Name	Amount	Hours	Name	Amount	Hours

The above amounts do **NOT** include child care billed to, or paid by the **SOUTH DAKOTA CHILD CARE ASSISTANCE PROGRAM, TRIBAL CHILD CARE ASSISTANCE, or any other source.**

_____ _____
Name of Provider (please print) Signature of Provider

Address: _____

Phone Number _____

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With my signature, I declare and affirm under the penalties of perjury that this billing verification has been examined by me, and to the best of my knowledge and belief is in all things true and correct.

_____
Signature of Parent/Relative/Guardian

_____
Date